

Islands of safety are crucial for children because they provide the conditions under which development can proceed.

## Developmental and Therapeutic Aspects of Treating Infants and Toddlers Who Have Witnessed Violence

Theodore Gaensbauer, M.D. Trauma occurring early in life, particularly if severe, can have enduring developmental consequences. Fortunately, we are learning more and more about specific therapeutic approaches which can help to reduce the impact of such early trauma. Perhaps the most compelling way to illustrate the devastating long-term effects of trauma, and to examine the usefulness of particular therapeutic approaches is through the detailed presentation of an individual child. Although my contact with Kevin and his family (names and identifying details have been changed to preserve confidentiality) was for the purpose of evaluation, I believe that our meetings helped reduce the intensity of his response to the trauma he had suffered and suggested ways that Kevin could be helped in the future.

### Kevin and his family: Background history and symptomatology

Kevin was two-and-one-half years old when he, his mother, and fifteen-year-old half-sister were waiting in their car while his father went into a local convenience store late one evening to buy some bread. While in the store, his father became involved in an argument with two men, leading to a physical fight. The men pulled a knife, chased Kevin's father around the store, and stabbed him repeatedly. The family witnessed the entire confrontation in a state of panic. Kevin cried hysteri-

cally, "They're hurting my daddy" while his mother and sister attempted to seek help. The father died of his wounds shortly afterwards.

Kevin was referred to me for a forensic evaluation two years later, when he was four-and-one-half. I had the opportunity to review his medical records, interview his mother, and carry out three sessions with Kevin.

Immediately following his father's death, Kevin had shown characteristic symptoms of posttraumatic stress disorder (PTSD) (Scheeringa et al., 1994). He had great difficulty sleeping, with many frightened awakenings, though he had not described any specific dreams at that time. Two years later he was still afraid to go to sleep and would stay up until early morning, a pattern he shared with his mother and half-sister, who were also continuing to experience significant PTSD symptoms. Kevin demonstrated persisting reenactment play involving stabbing actions and threats with a knife, both with doll figures and in fights with siblings and peers. His play with dolls was prototypical "posttraumatic play" (Terr, 1983) involving repetitive, almost obsessive physical fighting between "good guys" and "bad guys." In contrast to most four-year-olds' stories, the good guys in Kevin's scenarios often got killed. At times Kevin would make a connection between the play and the trauma, saying his daddy was a good guy and the bad guys were like the ones who hurt his daddy.

Since his father's murder, Kevin had also shown a marked increase in aggressive behavior and angry outbursts: tearing up toys, hitting other

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children, and acting defiantly toward his mother and other caregivers. At the time of my evaluation, he was still trying to understand and accept the loss of his father. He would periodically ask his mother if his father was ever coming back or would make spontaneous comments such as "All we went for is bread, huh, Mommy?," as if he had not accepted his father's loss nor fully assimilated what had occurred. He had also expressed wishes to die and join his father in heaven, and on one occasion had stabbed himself in the nose with a fork, to the point of drawing blood.

Other typical PTSD symptoms included marked separation fears, particularly with his mother, startle reactions, a significantly reduced attention span, periods of hyperactivity and restlessness during which he seemed to be "bouncing off the walls," and language regression. Toilet training had also been disrupted. He had not achieved day-time bowel and bladder control until five months prior to my evaluation, and was continuing to show occasional wetting. His mother also described a marked personality change in the direction of sadness and withdrawal, in contrast to his previous happy, outgoing nature—"the sparkle is gone" was the way she put it.

### **Interviews with Kevin**

In my interviews, Kevin appeared as an engaging child who was capable of moments of enthusiasm and happiness and seemed to have age-appropriate developmental skills. At the same time, it was evident that the traumatic experience remained a preoccupying, centrally disturbing element in his psychic life, more than two years after the event.

At our first meeting, as I greeted him in the waiting room Kevin smiled happily and engaged me in conversation. However, as he approached he abruptly hit me in the leg. When I asked him why he hit me, he said it was because he thought I would hit him back. He then said that I didn't even know him and that he was afraid I didn't like him. The idea seemed to be that he felt physically at risk in meeting a man whom he didn't know and that he had hit me in a kind of preemptive strike.

When he entered the playroom, Kevin almost immediately found some GI Joe figures and began to play out physical fights, with the characters using swords instead of guns. As he was playing, he brought up the issue of "dads" in an indirect way, telling me his half-sister had two dads. This opened the door for me to ask him about his

family and how many dads he had. While initially hesitant, he said he would tell me a story about his dad and that his dad was dead. He told me his father's name, but then said that was all he was going to say. He got a toy gun and told me I was under arrest, but then he became the bad guy, stealing my money and then shooting me.

Shortly after this play, he became anxious and wanted to return to the waiting room to find his mother. She had told us prior to our going into my office that she was going to run a quick errand. Unfortunately, when we returned to the waiting room, she wasn't there. Kevin's anxiety quickly escalated. He refused my attempts at reassurance, and did not want to return to the playroom to wait. Instead, he went out the main door to my suite and began desperately trying to open doors to other offices on the corridor, searching for his mother. He became increasingly distraught, to the point that I even proposed going to the parking lot where we could meet his mother as soon as she returned. He asked several times what store his mother had gone to, and finally said "what if she went to \_\_\_!", and specifically named the store at which his father had been killed. He said, "I don't want her to go there," and when I asked him to elaborate, he said, "Someone could kill my mom!" He clearly was continuing to live with the very immediate fear of losing his mother in the same way that he had lost his father.

In our next session, Kevin's mother again did not remain with him, but left him with his half-sister, whom I was also seeing in evaluation. As in the first session, Kevin initially came into the playroom happily and resumed his play with the GI Joe figures. Since he seemed quite comfortable, I asked him at one point about his scared feelings from last time. He again told me he had been afraid that his mom would be killed. Almost immediately, he asked to leave the room to get his half-sister. With his half-sister present, he was able to share that he worried about his mother because of what had happened to his father, and to demonstrate very accurately how his father was stabbed. He described feeling very sad, said that he still thought about the stabbing a lot, and, after falling silent, nodded in a very poignant way when I asked him if it was hard to talk about. Though he was able to talk and to accept empathy from his half-sister and me, he was clearly under a great deal of tension, wringing his hands and making physical contact with his half-sister.

At one point, his sister commented about Kevin's difficulties sleeping by himself. Kevin agreed, saying he was scared of the dark and of scary movies. His sister observed that Kevin was also very scared of someone coming to get him. I wondered if Kevin worried about something happening to him like what happened to his dad. This interpretation was too much. Kevin paused, then asked in an angry way, "Why do I have to answer these questions?" I thought it a sign of strength that even in the midst of his anger, he was able to say that the reason he did not want to talk was because it made him afraid. His irritated response led into a discussion not only of his anger at me for asking so many questions, but also his angry feelings at home and at the bad guys who killed his father. He was, however, clearly at the edge of what he could handle, and soon after began to act more wildly and provocatively, climbing on the furniture and playing with items on my desk. We suspended further attempts to talk about his father, and eventually, Kevin fell asleep while I carried out an interview with his sister.

In our third session, Kevin was calmer and able to remain for the whole session. He again chose to play with the GI Joe figures. He had me hold a somewhat larger robot toy, as he knocked the robot over several times with the figure he was holding. He then abruptly seemed to become anxious, saying "I don't want to play this any more" and wanted me to put the robot away. My thought was that the process of dealing so directly with his father's loss in our sessions had caused a psychological shift. What had previously been emotionally blunted and unproductively repetitive posttraumatic play had become more therapeutically workable, affectively loaded reenactment play. Kevin's feelings had come closer to the surface.

Later in the session, Kevin acknowledged directly that he liked to play rather than talk because talking made him think about what happened to his father. He said he thought about his father most when he went to bed and that he was scared to go to sleep because he didn't like to be in the dark (his father was killed at night) and because he had bad dreams. When I asked if he could describe a bad dream, he said he had dreams about a movie he saw about clowns who had big, sharp teeth and killed people with them. While ostensibly related to a horror movie he had actually seen, the image had obvious associative

links to his father's death. He answered yes when I asked if he had bad dreams about what happened to his dad and also nodded when I asked if he thought a lot about his dad during the day, too.

I mentioned that his mother had told me that he missed his dad so much that he thought about going to heaven. He immediately responded, "I could kill myself." When I asked him how he said, "Easy. With a knife." A last observation, made toward the end of the session, related to Kevin's difficulties with other children. He said they made him nervous and so he hit them, a similar reason to the one he had given for hitting me in the first session.

Compounding his difficulties, Kevin's mother experienced severe posttraumatic and depressive symptoms herself and had not been able to consistently meet his emotional or physical needs, as exemplified by her unavailability during my first two interviews. Kevin thus not only lost his father, but in many respects lost his mother and any semblance of family stability as well. This no doubt contributed to the overriding preoccupation with his father's death shown by the entire family which had persisted despite extensive therapy for all of them in the interval between the trauma and the time I saw them.

### **Discussion: The impact of trauma on development**

My interviews with Kevin provide a framework for a number of points concerning the impact of trauma on children's development. The first relates to the various aspects of development which are potentially influenced by a trauma. (For a detailed examination of the developmental consequences of trauma, the reader is referred to the excellent review by Pynoos, Steinberg and Wraith [1995]). As a way of organizing my own clinical thinking, I have conceptualized seven different levels of potential developmental impact (Gaensbauer, 1994). I utilize these various levels of impact as a framework for thinking about therapeutic goals, with the thought that in an ideal therapy each of these areas will need to be addressed if the child is to regain his or her pre-trauma level of functioning. Kevin demonstrates significant impact in all but one of these possible levels.

1. The first and most immediate level involves characteristic posttraumatic symptoms such as reexperiencing, avoidance of reminders, numbing

of general responsiveness, and increased arousal, which are seen across a wide variety of traumas and which likely have a strong biological basis. All of these were seen in Kevin.

2. A second level relates to the associated feelings and psychological meanings connected to the particular circumstances of the trauma, such as depression, feelings of responsibility or guilt, or the search for omens, reflected, for example, in Kevin's repeated questions about why it was the family had gone to the convenience store in the first place.

3. A third level concerns disruption in developmental issues being worked on at the time that the trauma took place, for example, in Kevin's case issues of separation and independence, the modulation of anger and aggression, and toilet training.

4. A fourth level concerns disruption in subsequent developmental phases, as seen in the continuing dominance of posttraumatic symptoms and themes two years after the event, interfering with typical four-year-old developmental issues related to bodily integrity, gender identification (Kevin's identification with his father and his continuing grief were contributing to self-destructive impulses), and conscience development (evidenced in his confusion about whether to be the good guy or the bad guy in his role playing). It was also undermining his readiness to undertake activities outside the nuclear family, including school and peer relationships.

5. A fifth level involves effects of the child's symptoms and behavior on interactions with others. Kevin's perseverative reenactment play, his anxiety, his self-destructive behavior, and increased aggression had all placed great strains on his caregivers and playmates.

6. Sixth, there is the independent impact of a trauma on other family members, independent of the child's reactions. In this instance, Kevin's half-sister and mother witnessed the same trauma and experienced their own PTSD reactions. Even when parents or other family members have not been witnesses, their reactions can be intense and long-lasting, and influence their subsequent treatment of the child (Green and Solnit, 1964).

7. A seventh level, thankfully not as significant a concern in infants and toddlers and not an issue in Kevin's case, is the extent to which a trauma may bring up memories and feelings related to previous traumas.

Kevin's continuing preoccupation with the trauma, reflected in recurrent, affectively intense reexperiencing of the traumatic events, illustrates what I believe is a crucial mechanism in producing the kinds of distortions in developmental processes described above. Traumatic memories are, as Lenore Terr (1988) has described, powerfully imprinted on the child's psyche. These memories, however, are not represented by static photographic-type images, but rather appear as fluid mental representations characterized by multiple sensory modalities, intense affective reactions, and a sense of temporal sequence. I believe that although they may not know how to interpret it, even infants and toddlers have the capacity to carry this "movie" inside their heads, with repetitive "showings" being triggered either by internal or external cues (Gaensbauer, 1995). The movie, moreover, is not a set of actions seen on some internal screen, separate from the child's consciousness. Rather, the child experiences it as happening "now!" with all the associated perceptual, affective, and behavioral accompaniments. An example of such everyday reexperiencing would be Kevin's description that his playmates made him "nervous," so he hit them. Their proximity was perceived as threatening, elicited a sense of danger, and resulted in a defensive counterattack, all outside his awareness.

These enduring sensory-motor/affective representations and their "here and now" immediacy are thus not just disorganizing in nature, but instead come to play an organizing role in the child's development, coloring and distorting many subsequent experiences. The younger the child, the greater the risk that such reexperiencing will become integrated into the child's core identity rather than be experienced as a set of memories and feelings which is alien to the pre-trauma sense of self. For example, a 12-month-old girl who observed her mother gruesomely killed by a letter bomb appeared to be plagued by images of the scene, manifested by her drawings, dreams, and symptomatic reactions, accompanied by feelings of wildness and aggression. By age six, these representations and their affective accompaniments had become so intertwined with her identity that she was showing signs of a significant disjuncture in her sense of self—there was the "good Audrey," who was loving and happy, and the "bad Audrey," who was plagued with violent imagery and sadistic impulses (Gaensbauer, 1995).

The extent to which a trauma will be organizing in this distorting way will be dependent on many factors, including the severity of the trauma, the intensity of the traumatic affects, the degree of permanent loss or disability, the child's pre-trauma adjustment, and the quality of environmental support. The frequency of such affective reliving will also depend on the frequency of exposure to cues likely to trigger traumatic memories, with a trauma that is relatively isolated from the child's everyday experiences likely having a lesser impact. For example, if a trauma has occurred during a boat ride and the child in the course of everyday life is not exposed to water, one might hypothesize a lesser impact than when a trauma has occurred in a more everyday setting. I mention this because it highlights what I believe is an important contribution to the tremendously destructive impact of community and family violence on children. There is no place of safety if the child is flooded with reminders every day, or even every hour, of his or her life. If your father can be killed while doing something as simple as running a brief errand to a convenience store, how can you assume that any activity outside the home is safe? With family violence, not even the home is safe (Groves et al., 1993).

Islands of safety are so crucial for children because they provide the conditions under which development can proceed. A two-year-old child, involved in an auto accident in which a parent was killed, would become fearful that something terrible was again going to happen in a variety of everyday situations. Remarkably, however, he seemed able to participate happily with peers in his child care setting without having the anxiety triggered. The child care situation seemed to be an island of unencumbered tranquility where he was able to play enthusiastically and to grow. Kevin, unfortunately, experienced the worst of possible worlds. Though able to show moments of happiness and spontaneous play, such as those seen in his initial interactions with me, which reflected underlying strengths related to his previous happy adjustment, in his current environment he was awash with traumatic reminders. Given the catastrophic disruption in his family functioning, he experienced few moments of safety where his underlying strengths could be nurtured.

### **Guiding principles for psychotherapeutic treatment**

Given the severity of his trauma and the many levels of disturbance, the therapeutic challenge for Kevin and children like him is immense. As a guiding principle for psychotherapeutic treatment, I find Robert Pynoos' summary statement to be most apt—namely to help the patient re-experience the trauma and its meaning in affectively tolerable doses in the context of a safe environment, so that the overwhelming traumatic feelings can be mastered and adaptively integrated into the person's emotional life (Pynoos, 1990). Though obviously a narrow window for observing a therapeutic process and colored by the fact that their purpose was evaluation rather than therapy, the sessions with Kevin suggest how this principle might work in practice. I would like to briefly review the three sessions, highlighting certain therapeutic aspects.

In the first session, Kevin's posttraumatic play and his sharing of the information that his father was dead elicited anxiety and a desire for contact with his mother. In turn, her absence exacerbated in a very immediate way his anxious memories about his father and fears about losing her. While at the most immediate level the episode elicited strong efforts on my part to relieve his anxiety, it can also be seen as an opportunity for therapeutic reworking. It allowed me to observe and reflect back to him the intensity and persisting nature of his fears, and to help him separate the traumatic reliving from the current situation. I found it a sign of emotional strength that he was able to articulate his fear very clearly, thus enabling me to provide direct empathic support. Each such episode of emotional reliving, as it occurs, represents an opportunity to desensitize the intensity of the child's affect and enhance the child's awareness that his or her reactions are being driven by traumatic memories. In such contexts, I believe, general comforting and nurturance is not enough. It is important to make the connection for the child to the previous trauma ("You are scared because you are remembering what happened to your father"). If this connection is not made, the episode runs the risk of being experienced by the child as traumatizing—one more scary experience that he or she was lucky to get through—rather than being seen as an overdetermined response driven by internal forces.

In the second session, with his sister's support,

Kevin was able to share more about what had happened to his father, including demonstrating the actual attack. In this session, emotions initially coming to the fore were fear and sadness, followed by feelings of disorganization and anger when the sad feelings became overwhelming. The sequence enabled me to make the connection between his painful feelings of loss and his feelings of anger. Although the anger no doubt had many determinants which would need to be explored, a crucial element in the therapy of trauma is to help both child and parents to recognize when the child's aggression is related to traumatic experience, rather than to character faults or a developmental phase. The increased aggression and hyperactivity characteristically seen in posttraumatic reactions is very difficult for parents to deal with, and can often lead to destructive interactive patterns. Indeed, Kevin's sister became irritated with him in the session, which only increased Kevin's defiance.

This session with his sister also highlighted some of the benefits to carrying out therapeutic sessions with parents or other family members present, if they can handle it. As did Kevin's sister, parents can provide support that facilitates the child's emotional reworking and helps rebuild the child's sense of trust. The parents' presence will bring about many opportunities for the therapist to promote understanding of the child's reactions and reduce negative interactional cycles. For example, when his sister became irritated about Kevin's misbehavior, I pointed out the sequence leading to Kevin's anger, in an effort to increase the sister's tolerance. Parents can provide information about the child's symptoms at home, as Kevin's sister did in bringing up Kevin's fears and sleeping difficulties. They can also provide crucial information about how reenactment play in the office may be related to the traumatic experience, particularly with young children. For example, a three-year-old boy who had experienced a series of painful medical procedures when he was fifteen months of age placed a boy doll in a hospital bed and then aligned a toy crutch next to the boy's leg. While I did not appreciate the significance of this action, his mother told me that after one of his procedures he had had a splint extending down the side of his leg to protect an IV site (Gaensbauer, in press).

By the third session, despite the difficult emotional moments of the previous two sessions,

Kevin seemed to have developed increased comfort in my office. He was able to allow feelings of anxiety associated with his reenactment play to come to the surface without having to leave the room. As in each of the first two sessions, he provided further details about reactions we had previously explored, such as his bad dreams, and introduced new themes, such as his problems with peers and the loss-driven identification with his father leading to impulses to stab himself.

In the course of these three sessions, one can catch a glimpse—the tip of the iceberg, really—of the variety and complexity of Kevin's affective reactions to his tragic loss, and the ways these reactions can be manifested in a therapeutic setting. The crucial factor in the development of a therapeutic process is, in my opinion, the extent to which the traumatic affects can be identified and brought to the surface in a manageable way. In my questioning, I took Kevin to the edge of what he was able to tolerate. On a couple of occasions I unfortunately went over. I was certainly attempting to stay within the bounds of the manageable and believe from the evolution of the material that on balance I succeeded. Kevin's reactions certainly raise the question of therapeutic tact, and how active the therapist should be in focusing the child's attention on trauma issues. Kevin's situation was clouded by the fact that I was doing a forensic evaluation and needed to get information in a short period of time. These circumstances notwithstanding, I often tend to be active in attempting to elicit the child's reactions, since children are at times not able to carry out this necessary work on their own. This can be done through verbal communication or through reenactment play, both of which were relevant in Kevin's case. With younger children especially, I will often use structured situations which recreate the situational context in which the trauma occurred (Levy, 1939) and then encourage the child to play out "what happens next" as a way of helping children to express their memories and develop a more coherent narrative regarding the traumatic events (Gaensbauer and Siegel, 1995).

Though evaluative in nature, I believe that my meetings with Kevin contributed in some small measure to reducing the intensity of his traumatic affects, through the opportunity to share his tragedy. I believe that this sharing, a bit at a time, is ultimately the most important thing we have to offer.